		FOR OHF USE					

LL1

2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0040683

Facility Name: Alden-Long Grove Rehab & HC Ctr

Address: Box 2308, RFD Old Hicks Rd. (Number) | Long Grove (City) | 60047 (Zip Code)

County: Lake

Telephone Number: (773) 286-3883 **Fax #** (773) 286-3743

IDPA ID Number: 36-4003486

Date of Initial License for Current Owners: 03/01/95

Type of Ownership:

[ ]	VOLUNTARY,NON-PROFIT	[X]	PROPRIETARY	[ ]	GOVERNMENTAL
[ ]	Charitable Corp.	[ ]	Individual	[ ]	State
[ ]	Trust	[ ]	Partnership	[ ]	County
IRS Exemption Code ____		[X]	Corporation	[ ]	Other ____
		[ ]	"Sub-S" Corp.		
		[ ]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other ____		

In the event there are further questions about this report, please contact:
Name: Steven M. Kroll **Telephone Number:** (773) 286-3883

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/00 to 12/31/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) Steven M. Kroll
(Title) Chief Financial Officer

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Alden-Long Grove Rehab & HC Ctr # 0040683 Report Period Beginning: 1/1/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	248	Skilled (SNF)	248	90,768	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	248	TOTALS	248	90,768	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	6,188	1,632	3,693	11,513	8
9	SNF/PED					9
10	ICF	41,410	10,922	321	52,653	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	47,598	12,554	4,014	64,166	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 70.69%

D. How many bed-hold days during this year were paid by Public Aid?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 3/1/95

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 3/1/95 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 53 and days of care provided 2,991

Medicare Intermediary Administar Federal Inc.

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Alden-Long Grove Rehab & HC Ctr # 0040683 Report Period Beginning: 1/1/00 Ending: 12/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	390,188	49,175		439,363	870	440,233		440,233			1
2	Food Purchase		473,197		473,197	(35,038)	438,159	(19,978)	418,181			2
3	Housekeeping	277,095	58,775		335,870	1,556	337,426		337,426			3
4	Laundry	21,390	35,376		56,766		56,766		56,766			4
5	Heat and Other Utilities			127,153	127,153		127,153		127,153			5
6	Maintenance	38,978		257,443	296,421	150	296,571	15,192	311,763			6
7	Other (specify):*											7
8	**TOTAL General Services**	727,651	616,523	384,596	1,728,770	(32,462)	1,696,308	(4,786)	1,691,522			8
	B. Health Care and Programs											
9	Medical Director			19,400	19,400		19,400		19,400			9
10	Nursing and Medical Records	2,808,660	194,229	14,962	3,017,851	6,754	3,024,605	(2,327)	3,022,278			10
10a	Therapy	62,050		660	62,710	95	62,805		62,805			10a
11	Activities	143,312	4,464	2,691	150,467		150,467		150,467			11
12	Social Services	36,327		2,871	39,198		39,198		39,198			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	3,050,349	198,693	40,584	3,289,626	6,849	3,296,475	(2,327)	3,294,148			16
	C. General Administration											
17	Administrative	108,346			108,346		108,346		108,346			17
18	Directors Fees											18
19	Professional Services			725,454	725,454		725,454	(640,532)	84,922			19
20	Dues, Fees, Subscriptions & Promotions			91,812	91,812		91,812	(78,153)	13,659			20
21	Clerical & General Office Expenses	653,912	47,837	45,983	747,732	17	747,749	68,837	816,586			21
22	Employee Benefits & Payroll Taxes			489,380	489,380	25,596	514,976	66,992	581,968			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,520	3,520		3,520	16,921	20,441			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			63,286	63,286		63,286	180	63,466			26
27	Other (specify):*			12,000	12,000		12,000	(12,000)				27
28	**TOTAL General Administration**	762,258	47,837	1,431,435	2,241,530	25,613	2,267,143	(577,755)	1,689,388			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,540,258	863,053	1,856,615	7,259,926		7,259,926	(584,868)	6,675,058			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Alden-Long Grove Rehab & HC Ctr #0040683 Report Period Beginning: 1/1/00 Ending: 12/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			60,092	60,092		60,092	15,315	75,407			30
31	Amortization of Pre-Op. & Org.							2,073	2,073			31
32	Interest			159,150	159,150		159,150	1,632	160,782			32
33	Real Estate Taxes			86,874	86,874		86,874	7,335	94,209			33
34	Rent-Facility & Grounds			1,817,962	1,817,962		1,817,962	63,345	1,881,307			34
35	Rent-Equipment & Vehicles			9,019	9,019		9,019	23,196	32,215			35
36	Other (specify):*											36
37	**TOTAL Ownership**			2,133,097	2,133,097		2,133,097	112,896	2,245,993			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		156,716	478,736	635,452		635,452	(315,395)	320,057			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			136,152	136,152		136,152		136,152			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		156,716	614,888	771,604		771,604	(315,395)	456,209			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,540,258	1,019,769	4,604,600	10,164,627		10,164,627	(787,367)	9,377,260			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Alden-Long Grove Rehab & HC Ctr # 0040683 Report Period Beginning: 1/1/00 Ending: 12/31/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,920)	2		13
14	Non-Care Related Interest	(90)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(7,639)	32		18
19	Entertainment				19
20	Contributions	(3,226)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(12,000)	27		24
25	Fund Raising, Advertising and Promotional	(50,070)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(25,253)	20		28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (100,198)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(587,465)		34
35	Other- Attach Schedule	(99,704)		35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (687,169)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (787,367)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Alden-Long Grove Rehab & HC Ctr

ID# 0040683

Report Period Beginning: 1/1/00

Ending: 12/31/00

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	non-cost: hmo nursing supply (gl 5026)	$ 0	39	1
2	non-cost: hmo drugs supply (gl 5042)	(18,354)	39	2
3	non-cost: hmo therapy (gl 5040)	(128,006)	39	3
4	non-cost: part b therapy c/a's in 5212/5213/5214	(16,506)	39	4
5	non-cost: hmo isolation c/a (gl 5093)	0	39	5
6	non-cost: hmo oxygen c/a (gl 5080)	(123)	39	6
7	VENDING MACHINE INCOM (GL 4308)	(4,600)	2	7
8	COMMUNITY RELATIONS (GL 5726)	(260)	20	8
9	Adj. Rent to equal actual for year 2000(same as 1999)	63,345	34	9
10	reclass painting>$1500 for 2000 from ln 6 to pg 22	(8,699)	6	10
11	record deprec exp for 1999 painting reclass	4,429	6	11
12	record deprec exp for 2000 painting reclass	1,450	6	12
13	record deprec exp for 1998 painting reclass	5,659	6	13
14	balance deprec exp for defer. Maint.	1,960	6	14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
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78				78
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81				81
82				82
83				83
84				84
85				85
86				86
87				87
88				88
89				89
90	**Total**	(99,704)		90

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Alden-Long Grove Rehab & HC Ctr **#** 0040683 **Report Period Beginning:** 1/1/00 **Ending:** 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(6,520)	0	0	(13,458)	0	0	0	0	0	0	0	(19,978)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	4,799	0	10,393	0	0	0	0	0	0	0	0	15,192	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(1,721)	0	10,393	(13,458)	0	0	0	0	0	0	0	(4,786)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	(2,327)	0	0	0	0	0	0	(2,327)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	(2,327)	0	0	0	0	0	0	(2,327)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	(640,509)	0	0	0	0	(23)	0	0	0	(640,532)	19
20	Fees, Subscriptions & Promotions	(78,809)	0	656	0	0	0	0	0	0	0	0	(78,153)	20
21	Clerical & General Office Expenses	0	0	43,788	15,356	9,693	0	0	0	0	0	0	68,837	21
22	Employee Benefits & Payroll Taxes	0	0	67,297	0	(305)	0	0	0	0	0	0	66,992	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	16,921	0	0	0	0	0	0	0	0	16,921	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	180	0	0	0	0	0	0	0	0	180	26
27	Other (specify):*	(12,000)	0	0	0	0	0	0	0	0	0	0	(12,000)	27
28	**TOTAL General Administration**	(90,809)	0	(511,667)	15,356	9,388	0	0	(23)	0	0	0	(577,755)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(92,530)	0	(501,274)	1,898	7,061	0	0	(23)	0	0	0	(584,868)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Alden-Long Grove Rehab & HC Ctr** **#** **0040683** **Report Period Beginning:** **1/1/00** **Ending:** **12/31/00**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	0	15,315	0	0	0	0	0	0	0	0	15,315	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	2,073	0	0	0	0	2,073	31
32	Interest	(7,729)	0	5,931	0	0	0	3,430	0	0	0	0	1,632	32
33	Real Estate Taxes	0	0	7,335	0	0	0	0	0	0	0	0	7,335	33
34	Rent-Facility & Grounds	63,345	0	0	0	0	0	0	0	0	0	0	63,345	34
35	Rent-Equipment & Vehicles	0	0	23,196	0	0	0	0	0	0	0	0	23,196	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	55,616	0	51,777	0	0	0	5,503	0	0	0	0	112,896	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	(162,988)	0	0	(17,333)	(32,381)	0	(102,693)	0	0	0	0	(315,395)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	(162,988)	0	0	(17,333)	(32,381)	0	(102,693)	0	0	0	0	(315,395)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(199,902)	0	(449,497)	(15,435)	(25,320)	0	(97,190)	(23)	0	0	0	(787,367)	45

Facility Name & ID Number Alden-Long Grove Rehab & HC Ctr # 0040683 Report Period Beginning: 1/1/00 Ending: 12/31/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
ALDEN MANAGEMENT SERV., INC	100%	SEE PG. 6K-TOO MANY TO FIT HERE.				

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V				$			$	$	1
2	V									2
3	V									3
4	V									4
5	V									5
6	V									6
7	V									7
8	V									8
9	V									9
10	V									10
11	V									11
12	V									12
13	V									13
14	Total				$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Alden-Long Grove Rehab & HC Ctr # 0040683 Report Period Beginning: 1/1/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	maintenance/utilities	$	Alden Management Services, Inc.	100.00%	$ 10,393	$ 10,393	15
16	V	19	professional fees	654,751	Alden Management Services, Inc.		14,242	(640,509)	16
17	V	20	licenses/fees		Alden Management Services, Inc.		656	656	17
18	V	21	gen'l & admin		Alden Management Services, Inc.		43,788	43,788	18
19	V	22	employee costs		Alden Management Services, Inc.		67,297	67,297	19
20	V	24	auto/seminar		Alden Management Services, Inc.		16,921	16,921	20
21	V	26	insurance		Alden Management Services, Inc.		180	180	21
22	V	30	depreciation		Alden Management Services, Inc.		15,315	15,315	22
23	V	32	interest		Alden Management Services, Inc.		5,931	5,931	23
24	V	33	real estate tax		Alden Management Services, Inc.		7,335	7,335	24
25	V	35	auto lease		Alden Management Services, Inc.		23,196	23,196	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 654,751			$ 205,254	$ * (449,497)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Alden-Long Grove Rehab & HC Ctr # 0040683 Report Period Beginning: 1/1/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	2	tube feeding	$ 30,610	Pyramid Healthcare Services	0.00%	$ 17,152	$ (13,458)	15
16	V	39	nursing supplies	9,568	Pyramid Healthcare Services		4,959	(4,609)	16
17	V	39	suppliess / per diem fees	35,344	Pyramid Healthcare Services		22,620	(12,724)	17
18	V	21	general & administrative		Pyramid Healthcare Services		15,356	15,356	18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 75,522			$ 60,087	$ * (15,435)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Alden-Long Grove Rehab & HC Ctr # 0040683 Report Period Beginning: 1/1/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	drugs	$ 102,296	Forum Extended Care II	0.00%	$ 77,001	$ (25,295)	15
16	V	10	house stock	9,413	Forum Extended Care II		7,086	(2,327)	16
17	V	39	iv	28,656	Forum Extended Care II		21,570	(7,086)	17
18	V	22	employee vaccinations	1,234	Forum Extended Care II		929	(305)	18
19	V	21	general & administrative		Forum Extended Care II		9,693	9,693	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 141,599			$ 116,279	$ * (25,320)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Alden-Long Grove Rehab & HC Ctr # 0040683 Report Period Beginning: 1/1/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	CPT REVENUES	$ 296,395	COMMUNITY PHYSICAL THERAPY	100.00%	$ 193,702	$ (102,693)	15
16	V	31	AMORTIZATION		COMMUNITY PHYSICAL THERAPY		2,073	2,073	16
17	V	32	INTEREST		COMMUNITY PHYSICAL THERAPY		3,430	3,430	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 296,395			$ 199,205	$ * (97,190)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Alden-Long Grove Rehab & HC Ctr # 0040683 Report Period Beginning: 1/1/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	construction management fees	$ 1,650	ALDEN BENNETT CONSTRUCTION	0.00%	$ 1,627	$ (23)	15
16	V	19	design fees	3,094	ALDEN DESIGN		3,094		16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 4,744			$ 4,721	$ * (23)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Alden-Long Grove Rehab & HC Ctr # 0040683 Report Period Beginning: 1/1/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week: Hours	Percent	Compensation Included in Costs for this Reporting Period**: Description	Amount	Schedule V. Line & Column Reference	
1	Floyd Schlossberg	President - AMS	CEO	100.00%	181,564	2.652	6.63	Salary	$ 12,882	21-1	1
2	Lauren Magnusson	Clinical Coordinator	Nursing/Review	a	69,556	2.652	6.63	Salary	4,935	21-1	2
3	Terry Magnusson	Administrator/Other	Admin/Maint	b	71,588	2.652	6.63	Salary	2,032	21-1	3
4	Audra Schlossberg	Massage/Therapist	Massage/Therapy	c	6,191	0.198	0.00	fees	660	10a-3	4
5											5
6											6
7											7
8											8
9	a. Lauren Magnusson is the daughter of Floyd Schlossberg and worked as a Clinical Coordinator for Alden Management Services for all of 2000.										9
10	b. Terry Magnusson is the son-in-law of Floyd Schlossberg and worked as the Administrator of Alden-Valley Ridge for 7 months thereafter he worked as in										10
11	Construction / Maintenance for Alden Management Services.										11
12	c. Audra Schlossberg is the daughter of Floyd Schlossberg and worked as a Massage Therapist during the year 2000.										12
13								TOTAL	$ 20,510		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees)
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Alden-Long Grove Rehab & HC Ctr # 0040683 Report Period Beginning: 1/1/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Alden Management Services, Inc.
Street Address: 4200 W. Peterson
City / State / Zip Code: Chicago, Illinois 60646
Phone Number: (773) 286-3883
Fax Number: (773) 286 -3743

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2		SEE PAGE 8 A								2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Alden-Long Grove Rehab & HC Ctr # 0040683 Report Period Beginning: 1/1/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	RELATED PARTY - AMS	X		OPERATIONS	NONE					VARIOUS	5,931	6
7	RELATED PARTY- CPT	X		OPERATIONS	NONE					VARIOUS	3,430	7
8	LINE OF CREDIT - affiliates	X		OPERATIONS	NONE					VARIOUS	151,511	8
9	TOTAL Facility Related						$	$			$ 160,872	9
	B. Non-Facility Related*											
10	INTEREST INCOME			NON ALLOWABLE							(90)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (90)	14
15	TOTALS (line 9+line14)						$	$			$ 160,782	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Alden-Long Grove Rehab & HC Ctr **#** 0040683 **Report Period Beginning:** 1/1/00 **Ending:** 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	95,189	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	88,811	2
3. Under or (over) accrual (line 2 minus line 1).	$	(6,378)	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	93,252	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	86,874	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1995	143,425	8
	1996	82,889	9
	1997	89,318	10
	1998	90,656	11
	1999	88,811	12

LINE4: 2000 ACCRUAL BASED ON 5% INCREASE OF PRIOR YEAR BILL: 88,811*1.05=93,252.

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number Alden-Long Grove Rehab & HC Ctr # 0040683 Report Period Beginning: 1/1/00 Ending: 12/31/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 89,632 B. General Construction Type: Exterior BRICK Frame STEEL Number of Stories 2

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [ ] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number Alden-Long Grove Rehab & HC Ctr # 0040683 Report Period Beginning: 1/1/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	SHELVING			1995	5,122	256	20	256		1,473	9
10	ROOF REPAIR			1995	3,000	300	10	300		1,700	10
11	STEAMER REPAIR			1995	2,686	269	10	269		1,522	11
12	EXIT DOOR-FIRE			1995	4,225	282	15	282		1,526	12
13	REPAIR BOILER/HVAC-MAJ.REP.			1995	4,712	628	5	628		4,712	13
14	PIPE/VALVE/THERMOSTAT			1996	1,460	73	20	73		383	14
15	ELECTRICAL REPAIR/INSTALLATION			1996	2,110	106	20	106		519	15
16	SIGN			1996	7,233	1,447	5	1,447		6,268	16
17	WATER HEATER ON DISHWASHER			1996	7,464	746	10	746		3,483	17
18	WALLGUARD			1996	2,096	140	15	140		629	18
19	INSTALL BOILER-MAJ.REP.			1996	33,750	1,688	20	1,688		7,453	19
20	REPLACE CONDENSOR WALK IN COOLER			1996	5,514	551	10	551		2,435	20
21	INSTALL ALUM. LOGO			1996	1,995	166	12	166		873	21
22	DESIGN SERVICE			1996	8,100	405	20	405		1,721	22
23	WASHROOM IMPROVEMENTS			1996	2,186	109	20	109		474	23
24	PIPING-MAJ.REP.			1996	4,000	267	15	267		1,089	24
25	PIPING-MAJ.REP.			1996	3,500	233	15	233		992	25
26	ATASH(replaced heat detector&fire dampers)			1997	959	192	5	192		751	26
27	ATASH(installed access panels)			1997	924	185	5	185		723	27
28	ATASH(fire alarm repairs)			1997	2,212	442	5	442		1,733	28
29	CLIMATE(installation of water heaters)			1997	7,342	1,468	5	1,468		5,629	29
30	CLIMATE(replced hydro.boiler)			1997	4,568	914	5	914		3,426	30
31	Wally's flooring(install new tiles).			1997	2,659	532	5	532		1,906	31
32	ATASH(SPRINKLER WORK)INV.#9120&9121			1997	3,072	614	5	614		2,304	32
33	ATASH(SPRINKLER WORKS)			1997	2,062	412	5	412		1,650	33
34	Climate srvc(two water heater)			1997	15,600	3,120	5	3,120		12,200	34
35	continue on next page…										35
36	TOTAL (lines 4 thru 35)				$ 138,552	$ 15,545		$ 15,545	$	$ 67,574	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Alden-Long Grove Rehab & HC Ctr # 0040683 Report Period Beginning: 1/1/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Wigdahl(install light fixtures)			1997	7,207	1,441	5	1,441		5,285	9
10	Wigdahl(install light fixtures)			1997	6,204	1,241	5	1,241		4,342	10
11	Climate(install compressor)			1997	6,750	1,350	5	1,350		4,725	11
12	Star contractor(door frame)			1997	2,973	95	5	95		2,031	12
13	Wally's flooring(install new tiles).			1997	2,659	532	5	532		1,994	13
14	Climate svcs(new pipe and air vents)			1997	6,354	1,271	5	1,271		4,236	14
15	EQUIPMENT INT'L LTD. (labor, parts, assembly)			1997	2,542	508	5	508		1,610	15
16	DOOR			1997	3,109	311	10	311		1,166	16
17	INSTALL NEW DROP CEILING			1997	2,175	181	12	181		680	17
18	DESIGN SERVICES			1997	931	47	20	47		182	18
19	NEW DRIVEWAY LIGHTING			1998	8,101	540	15	540		1,575	19
20	REPLACE WASHING MACHINE MOTORS			1998	1,752	350	5	350		1,022	20
21	REPLACE BOILER			1998	4,253	212	20	212		619	21
22	REPAIR PUMP MOTOR			1998	3,312	662	5	662		1,932	22
23	REPAIR DRYERS			1998	2,554	253	10	253		718	23
24	REPAIR EMEGENCY CIRCUITS			1998	1,510	151	10	151		428	24
25	REPAIR EMEGENCY LIGHTING SYSTEM			1998	273	27	10	27		77	25
26	REPLAC E COMPRESSOR			1998	1,301	130	10	130		369	26
27	REPLACE SEAVES ON ROOF			1998	10,500	700	15	700		1,692	27
28	REPLACE HOT WATER HEATER			1998	2,200	220	10	220		550	28
29	REPAIR GENERATOR			1998	5,228	349	15	349		813	29
30	REPLACE BEARING IN WASHER			1998	1,296	65	20	65		157	30
31	PATTEN-REPAIR GENERATOR			1998	655	33	20	33		79	31
32	PATTEN-REPAIR GENERATOR			1998	1,738	116	15	116		251	32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 85,576	$ 10,785		$ 10,785	$	$ 36,533	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Alden-Long Grove Rehab & HC Ctr # 0040683 Report Period Beginning: 1/1/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	D.B.S. Contracting(sprinkler system installation)			1999	32,838	1,314	25	1,314		2,518	9
10	D.B.S. Contracting(sleeve pipeline for sprinkler system)			1999	5,720	572	10	572		1,096	10
11	Hobart(repair dishwasher)			1999	2,560	256	10	256		448	11
12	Climate Service (pipework for boiler and storage tank)			1999	2,032	406	5	406		711	12
13	D.B.S. Contracting (need invoice)			1999	3,425	343	10	343		542	13
14	Chicago Cooling (repair pump)			1999	2,482	496	5	496		786	14
15	AMC Building Material			1999	4,544	454	10	454		719	15
16	AMC Sprinklers			1999	4,238	424	10	424		600	16
17	System Electric(generator repair)			1999	2,720	272	10	272		340	17
18	Patten Industries(install starter)			1999	5,495	550	10	550		687	18
19	AMC Building Material			1999	2,063	206	10	206		258	19
20	Fox Valley(sprinkler repair)			1999	1,803	120	15	120		140	20
21	Alden Bennet Cons.install tank)			1999	6,201	628	10	628		680	21
22	Alden Bennet Cons.(repair wind damage)			1999	33,802	1,368	25	1,368		1,482	22
23	AMC Security system			1999	7,273	727	10	727		788	23
24	AMC carpentry			1999	9,435	943	10	943		1,022	24
25	Climate Service (repair HVAC)			1999	9,358	936	10	936		1,014	25
26	ABC-construction mainten. Adjustment-various			1999	6,129	613	10	613		613	26
27	Climate services (A/C REPAIR)			2000	2,482	496	5	496		496	27
28	US foodservice (Steam table for fine dining room)			2000	9,816	600	15	600		600	28
29	B&L Locksmith (knob set)			2000	3,750	208	15	208		208	29
30	Alden Bennett Construction (major repairs)			2000	1,791	179	5	179		179	30
31	D.B.S. Contracting (repair lawn sprikler system)			2000	1,635	164	5	164		164	31
32	D.B.S. Contracting (repair lawn sprikler system)			2000	2,285	229	5	229		229	32
33	Alden Bennett Construction (major repairs)			2000	2,907	97	10	97		97	33
34	Alden Bennett Construction (time & material billing per fac)			2000	2,315	19	10	19		19	34
35	continue…										35
36	TOTAL (lines 4 thru 35)				$ 169,097	$ 12,620		$ 12,620	$	$ 16,437	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Alden-Long Grove Rehab & HC Ctr # 0040683 Report Period Beginning: 1/1/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	alden design-architectural/designing			2000	2,628	55	20	55		55	9
10	alden design-architectural/designing			2000	3,300	69	20	69		69	10
11	ABC-time & materials-maj. Leasehold improv-various			2000	2,110	47	15	47		47	11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 8,039	$ 170		$ 170	$	$ 170	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Alden-Long Grove Rehab & HC Ctr # 0040683 Report Period Beginning: 1/1/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	Related			1978	$ 12,184	$ 554	22	$ 554	$	$ 11,565	4
5	Party			1978	5,953	271	32	271		4,767	5
6	(Forum)										6
7											7
8											8
	Improvement Type**										
9	Related Party - AMS:										9
10	Leasehold Improvement - Remodeling			1993	5,378	223	various	223		115,184	10
11	Leasehold Improvement - Remodeling			1994	2,663	407	various	407		55,299	11
12											12
13	Related Party - Forum:										13
14	Leasehold Improvement - Remodeling			1980	19,102	955	20	955		19,102	14
15	Leasehold Improvement - Remodeling			1980	113		10			113	15
16	Leasehold Improvement - Remodeling			1986	32		6			32	16
17	Leasehold Improvement - Remodeling			1990	51		5			51	17
18	Leasehold Improvement - Remodeling			1991	12		5			12	18
19	Leasehold Improvement - Remodeling			1993	4,085	408	10	408		4,085	19
20	Leasehold Improvement - Remodeling			1993	3,199	330	9.7	330		3,058	20
21	Leasehold Improvement - SIGN			1994	258	21	10	21		145	21
22	Leasehold Improvement - DRYVIT			1994	437	44	12	44		244	22
23	Leasehold Improvement - NEW AC			1995	714	48	10	48		71	23
24	Leasehold Improvement - Roof			1997	961	51	10	51		760	24
25	Leasehold Improvement - Roof			1998	853	57	10	57		369	25
26	Leasehold Improvements-Roof			1985	809	54	19	54		175	26
27	Leasehold Improvements-Roof			1999	1,373	92	15	92		198	27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 58,177	$ 3,514		$ 3,514	$	$ 215,231	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Alden-Long Grove Rehab & HC Ctr # 0040683 Report Period Beginning: 1/1/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 216,373	$ 25,501	$ 25,501	$	various	$ 91,167	37
38	Current Year Purchases	37,048	3,563	3,563		various	3,563	38
39	Fully Depreciated Assets	22,253	1,214	1,214		various	22,253	39
40								40
41	TOTALS	$ 275,674	$ 30,278	$ 30,278	$		$ 116,983	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	various	busses, van, engine	1998-2000	$ 26,682	$ 2,494	$ 2,494	$	3	$ 3,030	42
43		1998-2000								43
44										44
45										45
46	TOTALS			$ 26,682	$ 2,494	$ 2,494	$		$ 3,030	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 761,797	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 75,407	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 75,407	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 455,959	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Alden-Long Grove Rehab & HC Ctr # 0040683 Report Period Beginning: 1/1/00 Ending: 12/31/00

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: T.L. ENTERPRISES: TRUST NO.170

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [X] YES [ ] NO Terms: PURCHASE OPTION DEPOSIT *

10. Effective dates of current rental agreement:
Beginning 3/1/95
Ending 3/1/01

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	12/31/00	$ 1,814,807
13.	12/31/01	$ 1,846,929
14.	12/31/02	$ 1,868,484

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ 5,168 Description: COPY MACHINE LEASE
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Alden-Long Grove Rehab & HC Ctr # 0040683 Report Period Beginning: 1/1/00 Ending: 12/31/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   SKILLED NURSING IS ALREADY ON SITE

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	$		$ 22,223	$		$ 22,223	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			140,384			140,384	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			133,789			133,789	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	SEE PG 16A…	# of prescrpts				52,995		52,995	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):	SEE PG 16A…					(29,334)		(29,334)	13
14	TOTAL			$		$ 296,396	$ 23,661		$ 320,057	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Alden-Long Grove Rehab & HC Ctr # 0040683 Report Period Beginning: 1/1/00 Ending: 12/31/00

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/00 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ (16,378)	$	1
2	Cash-Patient Deposits	40,948		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (48,469))	2,486,153		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	185,474		6
7	Other Prepaid Expenses	5,225		7
8	Accounts Receivable (owners or related parties)	25,321		8
9	Other(specify):	(30,029)		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,696,715	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	532,856		15
16	Equipment, at Historical Cost	205,585		16
17	Accumulated Depreciation (book methods)	(292,549)		17
18	Deferred Charges	54,757		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):	744,000		22
23	Other(specify): Construction in Progress	692,837		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,937,486	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,634,202	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 2,528,959	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	43,716		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	250,175		30
31	Accrued Taxes Payable (excluding real estate taxes)	90,545		31
32	Accrued Real Estate Taxes(Sch.IX-B)	93,252		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	(1,426,283)		35
	Other Current Liabilities(specify):			
36	Third Party	5,036,953		36
37	Other Current Liability	1,151,476		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 7,768,794	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 7,768,794	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (3,150,379)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,618,415	$	48

***(See instructions.)**

Facility Name & ID Number Alden-Long Grove Rehab & HC Ctr # 0040683 Report Period Beginning: 1/1/00 Ending: 12/31/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ (2,702,418)	1	
2	Restatements (describe):		2	
3	**External auditors' adjustments made after 1999 cost report**		3	
4	**was filed. These adjustetments had no effect on allowable costs:**		4	
5	**only bad debt expense and medicare revenue were adjusted.**	1,084,485	5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,617,933)	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(1,532,446)	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	( )	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (1,532,446)	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (3,150,379)	24	*

*** This must agree with page 17, line 47.**

Facility Name & ID Number Alden-Long Grove Rehab & HC Ctr # 0040683 Report Period Beginning: 1/1/00 Ending: 12/31/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 7,883,872	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,883,872	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	216,151	6
7	Oxygen	5,658	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 221,809	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	639	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	(13,164)	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ (12,525)	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	90	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 90	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Adjustments due to prior year expenses. Since prior yr.	17,161	28
28a	rep were not used we made no adj's on p. 5 or 5A.		28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 17,161	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,110,407	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,728,770	31
32	Health Care	3,289,626	32
33	General Administration	1,719,756	33
	B. Capital Expense		
34	Ownership	2,133,097	34
	C. Ancillary Expense		
35	Special Cost Centers	635,452	35
36	Provider Participation Fee	136,152	36
	D. Other Expenses (specify):		
37	Note: will not balance to page 3&4 due to related party amounts		37
38	being entered to these pages		38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 9,642,853	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,532,446)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,532,446)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? not yet done If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Alden-Long Grove Rehab & HC Ctr # 0040683 Report Period Beginning: 1/1/00 Ending: 12/31/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,992	2,080	$ 65,629	$ 31.55	1
2	Assistant Director of Nursing	1,200	1,991	49,784	25.00	2
3	Registered Nurses	40,082	43,289	1,051,661	24.29	3
4	Licensed Practical Nurses	7,324	7,942	166,910	21.02	4
5	Nurse Aides & Orderlies	113,086	115,584	1,457,331	12.61	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	7,281	7,467	62,663	8.39	8
9	Activity Director	2,024	2,080	43,686	21.00	9
10	Activity Assistants	7,280	7,660	99,626	13.01	10
11	Social Service Workers	3,946	4,230	53,059	12.54	11
12	Dietician					12
13	Food Service Supervisor	1,739	1,787	36,738	20.56	13
14	Head Cook	11,478	11,816	133,996	11.34	14
15	Cook Helpers/Assistants	26,430	27,506	219,454	7.98	15
16	Dishwashers					16
17	Maintenance Workers	3,294	3,410	38,978	11.43	17
18	Housekeepers	32,371	32,643	277,095	8.49	18
19	Laundry	3,211	3,259	21,390	6.56	19
20	Administrator					20
21	Assistant Administrator	616	720	18,787	26.09	21
22	Other Administrative	3,864	4,048	67,566	16.69	22
23	Office Manager	5,688	6,156	75,208	12.22	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	1,128	1,152	18,476	16.04	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Clinical supervisor	2,287	2,607	60,447	23.19	33
34	TOTAL (lines 1 - 33)	276,321	287,427	$ 4,018,484 *	$ 13.98	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	48	2,485	11-3	44
45	Social Service Consultant	12	618	12-3	45
46	Other(specify) PHYSCHO SOCIAL	4	219	12-3	46
47	ALZHEIMERS	32	1,635	12-3	47
48					48
49	TOTAL (lines 35 - 48)	96	$ 4,957		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Alden-Long Grove Rehab & HC Ctr # 0040683 Report Period Beginning: 1/1/00 Ending: 12/31/00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
STUART KANOWITZ	ADMINISTRATOR		$ 108,346
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 108,346

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
ALDEN MANAGEMENT SVS.	MNGT. FEES	$ 654,751
BLACKMAN KALLICK	ACCT. FEES	12,511
KENNETH FISCH	LEGAL FEES	26,378
GREENBERG & HERMAN	LEGAL FEES	17,217
MISC. LEGAL FEES	LEGAL FEES	1,927
ACHIEVE ACCREDITATION	JHCACO Consultant	2,894
MISC. PROF FEES	PROF. FEES	4,103
ALDEN DESIGN	DESIGN FEES	3,094
ALDEN BENNETT CONSTRUC	CONSTRUCTION FEES	1,650
US GAS	Utility Consultant	930
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 725,454

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 44,713
Unemployment Compensation Insurance	49,335
FICA Taxes	303,047
Employee Health Insurance	68,975
Employee Meals	35,038
Illinois Municipal Retirement Fund (IMRF)*	
RELATED PARTY	66,992
DENTAL / LIFE INSURANCE	2,977
EMPLOYEE RELATIONS	1,132
PAYROLL MISC. COSTS / TUIT REIMBURS	2,719
EMPLOYEE VACCINATIONS	1,234
SHUTTLE SERVICE	4,478
401 K MATCH	1,328
TOTAL (agree to Schedule V, line 22, col.8)	$ 581,968

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	1,797
Health Care Worker Background Check	150
(Indicate # of checks performed 21)	
RELATED PARTY	656
ICHA	10,481
MISC. SUBSCRIPTIONS	384
MISC INSPECTIONS	192
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 13,659

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
AUTO & TRAVEL	766
Seminar Expense	
EMPLOYEE SEMINARS	2,754
RELATED PARTY	16,921
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 20,441

**See instructions.

Facility Name & ID Number Alden-Long Grove Rehab & HC Ctr # 0040683 Report Period Beginning: 1/1/00 Ending: 12/31/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1	PLUMBING	9/95	$ 2,766	3	$ 922	$ 615	$ 0	$	$	$	$	$	$
2	PAINTING,SMOKE DET	12/95	3,737	3-10	947	876	128	128	128	128	128	128	128
3	PAINTING	1/96	2,369	3	790	789	0						
4	PAINTING	2/96	1,798	3	599	599	97	0					
5	PAINTING	3/96	1,844	3	615	615	102	0					
6	PAINTING	5/96	2,336	3	779	779	259	0		see page 22A for grand totals….			
7	PAINTING	4/96	12,094	3	4,031	4,031	1,008	0					
8	BOILER REPAIRS	5/96	2,100	3	700	700	233	0					
9	PAINTING	7/96	4,364	3	1,455	1,455	727	0					
10	PAINTING	6/96	2,141	3	714	714	297	0					
11	PAINTING	8/96	4,395	3	1,465	1,465	855	0					
12	PAINTING	9/96	1,606	3	535	535	358	0					
13	CHEMICAL FILTER	11/96	2,229	15	149	149	149	149	149	149	149	149	149
14	PAINTING	12/96	2,331	3	777	777	712	0					
15	Install compressor(hvac)	6/97	4,125	3	802	1,375	1,375	573	0				
16	painting	6/97	35,000	3	6,806	11,667	11,667	4,861	0				
17	hvac/hot water sensor	6/97	2,322	3	452	774	774	323	0				
18	water chiller/hvac	7/97	1,800	3	300	600	600	300	0				
19	boiler controller/hvac	11/97	3,125	3	174	1,042	1,042	868	0				
20	TOTALS		$ 92,482		$ 23,011	$ 29,556	$ 20,382	$ 7,202	$ 277	$ 277	$ 277	$ 277	$ 277

Facility Name & ID Number Alden Nursing Center - Long Grove STATE OF I ILLINOIS 0040683 Report Period Beginning: 1/1/99 Ending: 12/31/99

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XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	9	#	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year									
					FY1997	FY1998	FY1999	FY2000		FY2001	FY2002	FY2003	FY2004	FY2005
1	Climate Srv-repair pump	12/97	1,859	3	52	620	620	568		0				
2	Custom Appl-a/c's	1/98	2,940	3		980	980	980		0				
3	painting 1998	3/98	4,139	3		1,150	1,380	1,380		230	0			
4	painting 1998	6/98	5,582	3		1,085	1,861	1,861		776	0			
5	painting 1998	9/98	4,240	3		471	1,413	1,413		942	0			
6	painting 1998	12/98	3,014	3		84	1,005	1,005		921	0			
7	H.Scales-abt appliance	8/99	3,034	3			421	1,011		1,011	590			
8	CSI-flow switch/hvac	10/99	3,828	3			319	1,276		1,276	957	0		
9	Capps-sewer rodding	9/99	1,680	3			187	560		560	373	0		
10	CSI- hvac	12/99	2,482	3			69	827		827	758	0		
11	Painting>$1,500 ytd 1999	7/99	13,288	3			2,215	4,429		4,429	2,215	0		
12	CAPPS PLUMBING (SEWAGE	5/00	5,430	3				1,207		1,810	1,810	603	0	
13	VENDOR REC REVERSING		(2,482)	3										
14	GT MECHANICAL (chiller circ	8/00	1,523	3				212		508	508	295	0	
15	WRITE OFF CUST MAPP ?		(2,940)	3										
16	Alde Bennett Construction (time	12/00	21,314	3				592		7,105	7,105	6,512	0	
17	Painting>$1,500 ytd 2000	7/00	8,699	3				1,450		2,900	2,900	1,450	0	
18														
19	Totals from Page 22 . . .		92,482		23,011	29,556	20,382	7,202		277	277	277	277	277
20	TOTALS		$ 170,111		23,063	33,946	30,852	25,972		23,571	17,492	9,137	277	277

Facility Name & ID Number Alden-Long Grove Rehab & HC Ctr # 0040683 Report Period Beginning: 1/1/00 Ending: 12/31/00

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **Illinois Health Care Assoc. $9,624**

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YEARS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **64,307** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **136,152**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **35,038** Has any meal income been offset against related costs? **NO** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **0%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **YES**
Firm Name: **Blackman Kallick Bartelstein, LLP** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **NO** If no, please explain. **NOT YET COMPLETED**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees.